



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION IV  
611 RYAN PLAZA DRIVE, SUITE 400  
ARLINGTON, TEXAS 76011-4005

October 24, 2003

Harold B. Ray, Executive Vice President  
San Onofre, Units 2 and 3  
Southern California Edison Co.  
P.O. Box 128, Mail Stop D-3-F  
San Clemente, CA 92674-0128

SUBJECT: NRC ROUTINE INSPECTION REPORT 50-361/03-04; 50-362/03-04

Dear Mr. Ray:

On September 27, 2003, the NRC completed an inspection at your San Onofre Nuclear Generating Station, Units 2 and 3, facility. The enclosed report documents the inspection findings which were discussed on September 26 with Mr. J. Wambold and other members of your staff.

This inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. Within these areas, the inspection consisted of selected examination of procedures and representative records, observations of activities, and interviews with personnel.

Based on the results of this inspection, the NRC has identified an issue that was evaluated under the Risk Significance Determination process as having very low safety significance (Green). The NRC has also determined that a violation is associated with this issue. The violation is being treated as a noncited violation (NCV), consistent with Section VI.A of the Enforcement Policy. The NCV is described in the subject inspection report. If you contest the violation or significance of the NCV, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with copies to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the San Onofre Nuclear Generating Station, Units 2 and 3 facility.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response, if any, will be made available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Should you have any questions concerning this inspection, we will be pleased to discuss them with you.

Sincerely,

/RA/

Kriss M. Kennedy, Chief  
Project Branch C  
Division of Reactor Projects

Dockets: 50-361  
50-362

Licenses: NPF-10  
NPF-15

Enclosure:  
NRC Inspection Report  
50-361/03-04; 50-362/03-04

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U.S. NUCLEAR REGULATORY COMMISSION  
REGION IV

Dockets: 50-361, 50-362

Licenses: NPF-10, NPF-15

Report No.: 050361/2003004 and 50362/2003004

Licensee: Southern California Edison Co. (SCE)

Facility: San Onofre Nuclear Generating Station, Units 2 and 3

Location: 5000 S. Pacific Coast Hwy.  
San Clemente, California

Dates: June 29 through September 27, 2003

Inspectors: C. C. Osterholtz, Senior Resident Inspector, Project Branch C  
M. A. Sitek, Resident Inspector, Project Branch C

Approved By: Kriss M. Kennedy, Chief  
Project Branch C  
Division of Reactor Projects

## SUMMARY OF FINDINGS

IR05000361/2003004, 05000362/2003004; 06/29-09/27/2003; San Onofre Nuclear Generating Station, Units 2 and 3; Resident Report; Other.

The report covered a 3-month period of inspection by resident inspectors. One Green noncited violation (NCV) was identified. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter 0609, "Significance Determination Process." The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

A. NRC-Identified and Self-Revealing Findings

- Green. A noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, was identified as a result of inadequate corrective actions in response to the improper use of trichloroethane-based cleaners during linestarter maintenance. This resulted in unnecessary degradation of safety-related linestarter auxiliary contacts.

This issue was considered more than minor because the damage caused by improper maintenance practices to safety-related linestarters, if left uncorrected, could lead to a more significant safety concern in that a risk-significant valve could fail to perform its safety function. The finding was characterized under the Significance Determination Process as having very low safety significance because there was no actual impact on the safety-related function of any Unit 3 valve. Additionally, the results of the inspection of the remaining Unit 2 risk dominant valves, completed on July 11, 2003, did not result in any additional test failures (Section 4OA5).

B. Licensee-Identified Violations

None

ENCLOSURE

## REPORT DETAILS

### Summary of Plant Status

Both Units 2 and 3 began the period at approximately 100 percent power and remained at that level throughout the inspection period.

#### 1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity

##### 1R04 Equipment Alignment (71111.04)

###### a. Inspection Scope

Partial System Walkdowns. The inspectors performed four partial walkdowns during this inspection period. On July 8, 2003, the inspectors walked down the Unit 2 low pressure safety injection (LPSI) system Train B while preplanned routine maintenance activities were being performed on LPSI Train A Pump 2P015. On July 23, 2003, the inspectors walked down the Units' 2 and 3 portable power systems to Essential Plant Parameters Monitoring System Panels 2L411 and 3L411. On July 25, 2003, the inspectors walked down the Unit 3 normal cooling system for the Train A safety equipment room while the emergency room cooler, 3ME417, was out of service for corrective maintenance. On September 5, 2003, the inspectors walked down the Unit 3 high pressure safety injection (HPSI) system following the alignment of HPSI Pump 3P018 from HPSI Train A to HPSI Train B. To evaluate the operability of the selected train or system when the redundant train or system was inoperable or out of service, the inspectors checked for correct valve and power alignments by comparing positions of valves, switches, and electrical power breakers to the procedures listed below as well as applicable chapters of the Updated Final Safety Analysis Report:

- Operating Instruction SO23-3-2.7, "Safety Injection System Operation," Revision 19
- Piping and Instrument Diagram 40112BS03, "Safety Injection System No. 1204," Revision 33
- Work Authorization Record 2-0301294
- Abnormal Operating Instruction SO23-13-2, "Shutdown from Outside the Control Room," Revision 7-1
- Emergency Operating Instruction SO23-12-8, "Station Blackout," Revision 17
- Emergency Operating Instruction SO23-12-11, "EOI Supporting Attachments," Revision 1
- Operating Instruction SO23-1-8, "Safety Equipment Building HVAC," Revision 7

ENCLOSURE

- Operating Instruction SO23-3-2.7.2, "Safety Injection System Removal/Return to Service Operation," Revision 11
- Piping and Instrumentation Diagram 40112ASO3, "Safety Injection System No. 1204," Revision 35

Complete System Walkdown. The inspectors conducted a detailed review of the alignment and condition of the Unit 3 Train A saltwater cooling (SWC) and component cooling water (CCW) systems while the Train B SWC and CCW systems were out of service to repair SWC discharge Valve 3HV6201. The inspectors used the licensee procedures and other documents listed below to verify proper system alignment:

- Operating Instruction SO23-2-8, "Saltwater Cooling System Operation," Revision 25
- Operating Instruction SO23-2-8.1, "Saltwater Cooling System Alignments and Infrequent/Outage Operations," Revision 1-3
- Operating Instruction SO23-2-17, "Component Cooling Water System Operation," Revision 18
- Operating Instruction SO23-2-17.1, "Component Cooling Water System Alignments," Revision 6
- Operating Instruction SO23-3-2.7, "Safety Injection System Operation," Revision 19
- Operating Instruction SO23-3-2.7.2, "Safety Injection System Removal/Return to Service Operation," Revision 11
- Work Authorization Record 3-0301601
- Piping and Instrumentation Diagram 40126AS03, "Component Cooling Water Saltwater Cooling Pumps System No. 1203," Revision 15
- Piping and Instrumentation Diagram 40127C, "Component Cooling Water (Heat Exchangers) System No. 1203," Revision 38

The inspectors also verified electrical power requirements, labeling, hangers and support installation, and associated support systems status. Operating pumps were examined to ensure that any noticeable vibration was not excessive, pump leakoff was not excessive, bearings were not hot to the touch, and that the pumps were properly ventilated. The walkdowns also included evaluation of system piping and supports against the following considerations:

- Piping and pipe supports did not show evidence of water hammer.
- Snubbers did not appear to be leaking hydraulic fluid.
- Component foundations did not appear to be degraded.

b. Findings

No findings of significance were identified.

1R05 Fire Protection (71111.05)

a. Inspection Scope

The inspectors performed routine fire inspection tours, and reviewed relevant records, for the following six plant areas important to reactor safety:

- Train A Emergency Diesel Generator 2G002 room (Unit 2)
- Train B Emergency Diesel Generator 3G003 room (Unit 3)
- Train A primary switchgear room (Unit 3)
- Train B primary switchgear room (Unit 3)
- Secondary switchgear room (Unit 2)
- Control room vital cabinet area (Units 2 and 3)

The inspectors observed the material condition of plant fire protection equipment, the control of transient combustibles, and the operational status of barriers. The inspectors compared in-plant observations with the commitments in portions of the Updated Fire Hazards Analysis Report.

b. Findings

No findings of significance were identified.

.2 Annual Fire Drill Observation

a. Inspection Scope

On July 31, 2003, the inspectors observed an annual unannounced fire drill conducted by the licensee in Unit 2 Chiller Room 117 of the Unit 2/3 Auxiliary Control and Turbine Building. The inspectors reviewed Procedure SO123-XIII-21, "Fire Department Drills," Revision 8, and discussed the details of the drill with Fire Protection personnel. The inspectors also attended the postdrill critique.

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalifications (71111.11)

a. Inspection Scope

The inspectors reviewed licensed operator requalification training activities, including the licensed operators' performance and the evaluators' critique. The inspectors compared performance in the simulator on September 18, 2003, with performance observed in the control room during this inspection period.

The inspectors observed high-risk operator actions, operator activities associated with the emergency plan, and previous lessons-learned items. These items were evaluated to ensure that operator performance was consistent with protection of the reactor core during postulated accidents.

b. Findings

No findings of significance were identified.

1R12 Maintenance Effectiveness (71111.12)

.1 Safety Equipment Room Cooler Drain Blockage

a. Inspection Scope

The inspectors independently verified that the licensee appropriately handled safety significant component performance associated with plugged condensate drain lines in emergency cooling units located in safety equipment rooms. The inspectors reviewed Action Request (AR) 030500820 and discussed the plan for maintaining the condensate drain lines clear of debris with Engineering personnel.

b. Findings

No findings of significance were identified.

.2 Thermal Overload Tripping of Equipment

a. Inspection Scope

The inspectors independently verified that the licensee appropriately handled safety significant component performance associated with the tripping of equipment due to the actuation of thermal overload relays. The inspection was performed, in part, because in early 2002 the licensee discovered that the Cutler-Hammer thermal overload relays that are used for nonsafety-related equipment were susceptible to long-term, age-related heating damage. The inspectors also reviewed the licensee's plan for replacing the Cutler-Hammer relays with more robust Square-D relays. Additionally, the inspectors discussed a recent failure of a safety-related Square-D thermal overload relay with

Engineering personnel, and reviewed the licensee's plan to perform independent forensic analysis of the relay. The inspectors reviewed ARs 010101347, 030700894, 030700889, and 030701280 as part of the inspection.

1R13 Maintenance Risk Assessments and Emergent Work Evaluation (71111.13)

a. Inspection Scope

The inspectors verified the accuracy and completeness of risk assessment documents and that the licensee's maintenance risk assessment program was being appropriately implemented. The inspectors also ensured that plant personnel were aware of the appropriate licensee-established risk categories for maintenance activities, according to the risk assessment results and licensee program procedures.

The inspectors also reviewed selected emergent work items to ensure that overall plant risk was being properly managed and that appropriate corrective actions were being properly implemented.

The inspectors reviewed the effectiveness of risk assessment and risk management for the following two activities:

- Units 2 and 3 fire monitoring system ground fault alarms on April 15, 2003 (AR 030400792)
- Unit 2 steam generator level transient during plant startup in June 2003 (AR 030700034)

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations (71111.15)

a. Inspection Scope

The inspectors reviewed selected operability evaluations to evaluate technical adequacy and to verify that operability was justified. The inspectors considered the impact on compensatory measures for each condition being evaluated, and referenced the Updated Final Safety Analysis Report and Technical Specifications. The inspectors also discussed the evaluations with cognizant licensee personnel.

The inspectors reviewed three operability evaluations and cause assessments documented in the following ARs to ensure the operability was properly justified:

- AR 030800790: Unit 2/3 emergency diesel generators potentially expired air-line lubricator oil in the air-start systems

- AR 030401070: Unit 2/3 Diesel Fire Pump P220 not in pump curve requirements for total developed head
- AR 030800790: Unit 2 Emergency Diesel Generator 2G002 governor oil level high

b. Findings

No findings of significance were identified.

1R16 Operator Workarounds (71111.16)

a. Inspection Scope

Cumulative Effects. The inspectors reviewed four operator workaround items to evaluate their cumulative effects on the reliability, availability, and potential for misoperation of a system and on the ability of operators to respond in a correct and timely manner to plant transients and accidents. The inspection included a review of the licensee's criteria and processes used for identifying and tracking deficiencies as operator workarounds. The review also focused on the length of time the identified workarounds had been in existence and the efforts initiated to resolve them.

Individual Effects. The inspectors also reviewed the workarounds to determine if the functional capability of the systems or human reliability in responding to an initiating event was affected. The inspectors evaluated the effect that the workarounds had on the operator's ability to implement abnormal or emergency operating procedures.

- Manual restoration of carbon dioxide fire suppression isolation valve to Unit 2 enclosure for turbine bearings 6 and 7
- Unit 2 pressurizer spray valve control from Reactor Coolant Loop 1A
- Unit 3 condensate storage tank fill valve leakage
- Control Room Emergency Ventilation Supply Unit MA 206 fan reverse rotation

The inspectors also reviewed Procedure SO123-XX-6, "Operator Workaround Program," Revision 2, as part of this inspection.

b. Findings

No findings of significance were identified.

1R19 Postmaintenance Testing (71111.19)

a. Inspection Scope

The inspectors observed and/or reviewed postmaintenance testing for the following four activities to verify that the test procedures and activities adequately demonstrated system operability:

- Unit 2 Loop 2A LPSI Valve 2HV9328 linestarter postmaintenance test inspection per Procedure SO123-I-9.13, "480 VAC Linestarter Inspection, Coil, and Power Contact Replacement," Revision 3, performed on July 11, 2003
- Unit 3 Train B Saltwater Cooling Pump 3P113 Discharge Valve 3HV6201, postmaintenance test per Procedure SO23-I-6.300, "Air Operated Valve Testing, Evaluation, and Adjustment," Revision 5-2, performed on July 29, 2003. The inspectors also reviewed AR 030500400 and Maintenance Order (MO) 03050761000 as part of the inspection
- Unit 2 Emergency Diesel Generator 2G002 postmaintenance testing following scheduled preventive maintenance activities per MOs 02101043000, 03040404000, and 03071381000 performed on August 7 and 8, 2003

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing (71111.22)

a. Inspection Scope

The inspectors observed and/or reviewed performance and documentation for the following six surveillance tests to verify that the structures, systems, and components were capable of performing their intended safety functions and to assess their operational readiness:

- Unit 2 accelerometer operability surveillance test per MO 03030036001, "Obtain Baseline Data From and Perform Functional Test on Unit 2 Pressurizer Relief Accelerometers," performed on June 21, 2003
- Unit 2 Train A CCW Pump 2P024 loss of voltage surveillance test per Procedure SO2-II-11.1A-2, "Surveillance Requirement Unit 2 ESF [Engineered Safety Features] Train A Channel (Online) Test of Loss of Voltage (LOVS), Degraded Voltage (SDVS, DGVSS) and Sequencing Relays and Circuits," Revision 3, performed on July 8, 2003

- Unit 2 Train A LPSI Pump 2P015 loss of voltage surveillance test per Procedure SO2-II-11.1A-2, "Surveillance Requirement Unit 2 ESF Train A Channel (Online) Test of Loss of Voltage (LOVS), Degraded Voltage (SDVS, DGVSS) and Sequencing Relays and Circuits," Revision 3, performed on July 8, 2003
- Unit 2 Train A HPSI Pump 2P017 surveillance test per Procedure SO23-3-3.60.1, "High Pressure Safety Injection Pump and Valve Testing," Revision 3, performed on July 8, 2003
- Unit 2 remote and safe shutdown instrumentation surveillance test per Surveillance Operating Instruction SO23-3-3.28, "Remote Shutdown Monitoring Instrumentation (RSMI)/SSD Monthly Checks," Revision 12, performed on July 23, 2003
- Unit 2 Emergency Diesel Generator 2G002 monthly surveillance per Procedure SO23-3-3.23, "Diesel Generator Monthly and Semi-Annual Testing," Revision 22, performed on August 30, 2003

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications (71111.23)

a. Inspection Scope

The inspectors reviewed the following two temporary plant modifications to verify that the safety functions of safety systems were not affected:

- Temporary Engineering Change Package 030201804, "Revise the High Level Alarm Setpoint for the Quench Tank" (Unit 3)
- Temporary Engineering Change Package 030201804, "Add Jumper to Pulse Count Card" (Unit 3)

The inspectors also reviewed Procedures SO123-XV-5.10, "Temporary Facility Modification," Revision 1; SO123-XV-5.1, "Temporary Modification Control;" and SO123-XXIV-10.1, "Preparation, Review, Issuance, Implementation, and Closure of Engineering Change Packages and Engineering Change Notices," Revision 5, as part of this inspection.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES (OA)

4OA1 Performance Indicator Verification (71151)

a. Inspection Scope

The inspectors verified the accuracy of data reported by the licensee for the following two performance indicators to ensure that the performance indicator color was correct for both Units 2 and 3:

Reactor Safety Cornerstone

- MS3 Residual Heat Removal System Unavailability
- MS4 Auxiliary Feedwater System Unavailability

The inspectors reviewed the performance indicator data for the last two quarters of 2002 and the first two quarters of 2003. The inspectors reviewed NEI 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 2, and licensee operating logs. The inspectors discussed the status of the performance indicators and compilation of data with Engineering personnel.

b. Findings

No findings of significance were identified.

4OA2 Identification and Resolution of Problems (71152)

.1 Annual Sample Review

a. Inspection Scope

The inspectors selected AR 020801305 for a detailed review.

b. Findings and Observations

AR 020801305 was written in August 2002, after the speed of Emergency Diesel Generator 3G003 could not be adjusted from the control room during surveillance testing. The deficiency was attributed to a failed component that did not affect the ability of the diesel to automatically start and perform its intended safety function. During the course of investigation, the licensee discovered a new deficiency and potential failure mechanism for Potter and Brumfield motor-driven relays (see NRC Inspection Report 50-361, 362/2003003, Section 1R12.1). This deficiency and potential failure mechanism was documented in several assignments to AR 020801305. However, no new AR assignment was generated to identify the issue independently. Licensee personnel in several organizations were subsequently unaware of the new deficiency until questioned

about it by the inspectors. The inspectors were concerned that pertinent information may not have been adequately communicated between mutually concerned organizations and raised the concern to licensee management. The licensee agreed that a deficiency in the program existed and generated a new AR assignment (030901015). The new AR directed that guidance should be added to the licensee's corrective action program to provide for an additional review by the Action Review Committee when independent issues surface during the course of performing assignments to existing ARs. AR 030901015 was still open at the end of this inspection period. The inspectors considered the initiative to revise the corrective action program to be appropriate.

.2 Quarterly Review of Corrective Action Documents

a. Inspection Scope

The inspectors reviewed a selection of ARs written during this inspection period to determine if the licensee was entering conditions adverse to quality into the corrective action program at an appropriate threshold, to determine if the ARs were appropriately categorized and dispositioned in accordance with the licensee's procedures, and, in the case of conditions significantly adverse to quality, to determine if the licensee's root cause determination and extent of condition evaluation were accurate and of sufficient depth to prevent recurrence of the condition.

b. Findings

No findings of significance were identified.

4OA5 Other

(Closed) URI 05000361, 362/2003007-01: Failure to promptly identify and correct linestarter degradation

Introduction. A Green NCV was identified for failure to promptly identify and correct safety-related linestarter switch degradation due to repetitive improper use of a trichloroethane (TCE)-based cleaner. This was a violation of 10 CFR Part 50, Appendix B, Criterion XVI.

Description. During the NRC special team inspection performed during the week of March 10, 2003 (NRC Inspection Report 05000361, 362/2003-07 dated May 6, 2003), the inspectors identified a finding having potential safety significance greater than very low significance. The finding involved several missed opportunities from plant and industry operating experience to recognize the need for an extent of condition review to identify equipment degradation that occurred throughout the plant due to improper use of cleaning solvents. In April 1989 the licensee recognized that TCE-based cleaners were being used improperly and that controls needed to be implemented to prevent future damage to equipment containing plastics. The licensee reviewed Information

Notice 93-76, "Inadequate Control of Paint and Cleaners for Safety Related Equipment," and determined that the programs in place were sufficient to avoid similar problems to those discussed in the notice. In December 1996 the licensee identified relay and socket degradation on a Class 1E inverter. The licensee found that the degradation was caused by excessive application of a chemical cleaner. In each of these instances the licensee did not consider effects on plant equipment that may have resulted from past improper use of TCE-based cleaners.

This oversight revealed itself after a review of two failed Unit 3 motor-operated valve surveillance tests. The first failure was Low Pressure Safety Injection Minircirculation Valve 3HV8163 failing to open during a surveillance test conducted on August 30, 2002. The second failure was Quench Tank Sample Containment Isolation Valve 3HV0514 failing to open during a surveillance test conducted on January 18, 2003. Neither failure resulted in a loss of safety function for the respective valves. The licensee completed inspection and testing of all Unit 3 linestarters at the end of the special inspection and observed no additional line starter contact failures. However, the licensee had not yet tested the linestarters associated with the most risk dominant Unit 2 valves. As a result, the significance of the finding had not been determined at the conclusion of the special inspection.

The licensee determined the most risk dominant valves in Unit 2 through probabilistic risk assessment methods. Specifically, a Fussell-Vessely Risk Importance analysis was performed to determine the relative risk reduction associated with the population of the Unit 2 valves. The remaining valves that dominated risk were containment emergency sump Valves 2HV9303 and 2HV9305, auxiliary feedwater Valves 2HV4712 and 2HV47123, and saltwater cooling Valve 2HV6495.

On July 11, 2003, the licensee completed inspection and testing of all of the risk dominant motor-operated valves in Unit 2 with no observed failures.

Analysis. The inspectors evaluated the significance of the finding using the Significance Determination Process for both Units 2 and 3. The finding was determined to be more than minor because the damage caused by improper maintenance practices on safety-related linestarters, if left uncorrected, could lead to a more significant safety concern in that a risk significant valve could fail to perform its safety function. Therefore, the finding affected the reactor safety mitigating system cornerstone objective. However, the finding was determined to have very low safety significance because:

- (1) The results of the inspection and testing of the remaining Unit 2 risk dominant valves, completed on July 11, 2003, did not result in any additional test failures.
- (2) There was no actual impact on the safety-related function of any Unit 3 valve.

Enforcement. The regulations in 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," state, in part, that measures shall be established to assure that conditions adverse to quality, such as defective material and equipment, are promptly identified

and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition. Contrary to the above, the licensee missed several opportunities to recognize the need for an extent of condition review to promptly identify and correct defective material and equipment that occurred throughout the plant due to repetitive improper use of TCE-based cleaners. This violation of 10 CFR Part 50, Appendix B, Criterion XVI, is being treated as a noncited violation (NCV 361, 362/2003004-01) consistent with Section VI.A of the Enforcement Policy. This violation is in the licensee's corrective action program as ARs 020801672 and 030101366.

4OA6 Meetings, including Exit

On September 26, 2003, the resident inspectors presented the inspection results to Mr. J. Wambold and others who acknowledged the findings. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

ATTACHMENT: SUPPLEMENTAL INFORMATION

ENCLOSURE

## KEY POINTS OF CONTACT

### Licensee personnel

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R. Bockhorst, Manager, Electrical Maintenance Engineering  
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R. Waldo, Station Manager  
T. Yackle, Manager, Design Engineering  
J. Wambold, Vice President, Nuclear Generation

## LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

### Opened & Closed

05000361, 362/2003004-001      NCV      Failure to promptly identify and correct linestarter degradation

### Closed

05000361, 362/2003007-01      URI      Failure to promptly identify and correct linestarter degradation

### Discussed

None

## LIST OF ACRONYMS

AR	action request
CCW	component cooling water
CFR	<i>Code of Federal Regulations</i>
ESF	engineered safety feature
HPSI	high pressure safety injection
LPSI	low pressure safety injection
MO	maintenance order
SWC	saltwater cooling
TCE	trichloroethane
URI	unresolved item